

Quick Guide

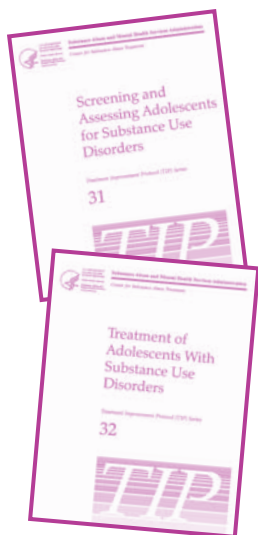
For Clinicians

Based on TIP 31

**Screening
and Assessing
Adolescents for
Substance Use
Disorders**

Based on TIP 32

**Treatment of
Adolescents With
Substance Use Disorders**



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

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Quick Guide

For Clinicians

Based on TIP 31

*Screening and Assessing
Adolescents for Substance
Use Disorders*

and TIP 32

*Treatment of Adolescents With
Substance Use Disorders*

This *Quick Guide* is based almost entirely on information contained in TIPs 31 and 32, published in 1999. No additional research has been conducted to update this topic since publication of the original TIPs.

WHY A QUICK GUIDE?

The purpose of a Quick Guide is to provide succinct, easily accessible information to busy clinicians.

This *Quick Guide* is based on TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders*, and TIP 32, *Treatment of Adolescents With Substance Use Disorders*, which are part of the Treatment Improvement Protocol (TIP) Series, published by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration. It will help substance abuse treatment providers assess adolescent patients and clients presenting with problems related to alcohol and drug abuse and communicable diseases.

For in-depth information on the topics in this Quick Guide, readers should refer to TIPs 31 and 32.

WHAT IS A TIP?

The TIP Series was launched in 1991. The goal of these publications is to disseminate consensus-based, field-tested guidelines on current topics to substance abuse treatment providers.

TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders*, provides information about

- Screening/assessing young people for substance use disorders
- Using techniques to detect and deal with related problems in adolescents' lives.

TIP 32, *Treatment of Adolescents With Substance Use Disorders*, provides information about

- Treatment needs of adolescents with substance use disorders
- The severity continuum
- Using interventions such as acute intervention, rehabilitation, and maintenance
- The three common types of treatment for adolescents: 12-Step treatment, therapeutic communities, and family therapy.

INTRODUCTION

Adolescents who use or abuse substances differ from adults physiologically and emotionally. Their drug and alcohol use may stem from different causes, and they have even more trouble projecting the consequences of their use into the future.

- Adverse consequences associated with adolescent substance use disorders include
- Fatal/nonfatal injuries from motor vehicle crashes and other accidents
- Suicides
- Homicides
- Violence
- Delinquency/criminal behavior
- Psychiatric disorders, neurological impairments, and other medical complications especially from using inhalants
- Risky sexual practices that increase susceptibility to human immunodeficiency virus (HIV) infection
- Impulsivity, alienation, and psychological distress.

SCREENING

Screening identifies youths who may have a significant substance use problem.

Screening identifies

- Red flags (indicators of serious substance-related problems) (see exhibit 31/32–1)
- Teens needing a more comprehensive assessment.

The screening or comprehensive assessment instruments should be

- Reliable, valid tools
- Tested or normed for use with adolescents
- Appropriate for the settings in which they are used
- Used for their intended purpose
- Simple enough for all types of health professionals to use.

Exhibit 31/32-1
Indicators for Adolescent Screening/Assessment

- Use during childhood or early teenage years
- Use before or during school
- Peer involvement in use
- Daily use of one or more substances
- History of physical or sexual abuse
- Parental substance abuse
- Sudden downturn in school performance or attendance
- Peer involvement in serious crime
- Marked change in physical health
- Involvement in serious delinquency or crime
- Risky activities that put adolescents at high risk for HIV
- Serious psychological problems (e.g., suicidal ideation, severe depression).

The screening process should

- Last 10–15 minutes
- Determine the severity of an adolescent's substance use
- Examine associated factors (e.g., legal problems, mental health status, educational functioning, living situation)
- Use structured or semistructured interviews or standardized paper-and-pencil questionnaires.

When screening, collect information from other sources (parents/other family members) if time permits. Collect information when youths are not present (but state that what is said may be shared with adolescents).

Generally, several or a few meaningful red flags indicate that referral is needed.

Who Should Screen Adolescents?

Any individual with proper screening training and experience working with adolescents may screen; for example,

- Healthcare providers, educators, clergy, and other professionals
- Juvenile justice system workers

- Mental health professionals (all youths being assessed for mental health disorders should be screened for substance use disorders because of the high correlation between the two disorders).

Who Should Be Screened?

Any teen who

- Shows increased oppositional behavior or substantial behavioral changes
- Shows significant changes in school functioning
- Has run away
- Has entered the child welfare system
- Drops out of school
- Needs emergency medical services
- Develops medical problems or an infection associated with substance abuse.

Screening Instruments

The following are a select sample of screening instruments:

Adolescent Drinking Index (ADI)

Contact: (800) 331-8378

Administered to individuals or groups

Time: 5 minutes

Cost: \$59 per kit

Adolescent Drug Involvement Scale (ADIS)**Contact:** (608) 263-1304**dpmoberg@facstaff.wisc.edu****Self-administered to individuals or groups****Time:** 6–8 minutes**Cost:** Free**Drug Use Screening Inventory–Revised (DUSI–R)****Contact:** (412) 524-1070**Self- or group-administered instrument****Time:** 35–60 minutes**Cost:** \$2 each**Personal Experience Screening Questionnaire (PESQ)****Contact:** (612) 626-2879**winte001@tc.umn.edu****Self-report questionnaire****Time:** 10 minutes**Cost:** \$70 per kit**Rutgers Alcohol Problem Index (RAPI)****Contact:** (732) 445-3579**Self-administered instrument****Time:** 13 minutes**Cost:** Free

(See TIP 31, appendix B and pages 63–124, for more detailed descriptions of screening instruments.)

Drug Monitoring

Laboratory tests for drugs

- Are useful in juvenile assessment centers/ detention facilities and crisis stabilization units
- Can be done on blood, urine, hair, and saliva.

Saliva and breath analyses for alcohol and urinalyses for drugs are reliable and relatively inexpensive.

Drug monitoring should be done at an appropriate point during screening and using accepted standards and guidelines. Personnel should be trained in proper testing procedures.

Exhibit 31/32-2 explains the length of time alcohol and drugs are detectable in tests.

Exhibit 31/32-2

Approximate Duration of Detectability of Alcohol and Selected Drugs*

Drug	Duration of Drug Detectability
Alcohol	Very short ⁺
Amphetamine	2–4 days
Methamphetamine	2–4 days
Barbiturates (most types)	2–4 days
Phenobarbital	Up to 30 days
Benzodiazepines	Up to 30 days
Cocaine	12–72 hours
Methadone	2–4 days
Opioids (heroin, codeine)	2–4 days
Marijuana (casual use)	2–7 days
Marijuana (chronic use)	Up to 30 days
Phencyclidine (PCP) (casual use)	2–7 days
PCP (chronic use)	Up to 30 days

* Many variables should be considered when using these general guidelines: drug metabolism and half-life; the youth's physical condition, fluid balance, hydration status; the route and frequency of ingestion.

⁺ The period of detection depends on the amount consumed. Approximately 1 ounce of alcohol is excreted per hour.

ASSESSMENT

- Do a comprehensive assessment if the screen is positive. Assessments
- Are more complex than the screening process
- May confirm the presence of a substance abuse problem
- May document the presence, nature, and complexity of substance use
- Help identify other problems
- Provide information that can be used to develop an appropriate intervention and determine treatment needs of clients.

Assessors

Assessors should be professionals such as mental health professionals, school counselors, social workers, or substance abuse counselors.

Assessors should have training and experience in

- Psychological assessment
- Use of standardized measures
- Adolescent developmental psychology
- Substance use disorders.

Multiple Assessment Approach

Substance abuse affects many areas of a youth's life, and no single factor causes it. Thus, many areas must be assessed, including the adolescent's

- Substance use history (include prescription and over-the-counter drugs, tobacco, and inhalants)
- Mental health (depression, suicidal ideation or attempts, attention deficit/hyperactivity disorder [AD/HD], conduct disorders, anxiety disorders, and behavioral disorders)
- Family history (substance use by parents/guardians/extended family, mental and physical health, and treatment)
- School experience (academic and behavioral performance and attendance)
- Social history (peer relationships, interpersonal skills, gang involvement, and neighborhood environment)
- Juvenile justice involvement
- Sexual history (sexual orientation, sexual activity, sexual abuse, sexually transmitted diseases [STDs], HIV status, and risky behaviors)
- Medical health status
- Strengths and resources (self-esteem, family, community supports, coping skills, and motivation for treatment).

With the adolescent's consent, gather information from

- Parents
- Other family members
- Adults and peers important to the youth.

Collect information through

- Interviews
- Observation
- Specialized testing.

Assessment Instruments

Well-designed questionnaires and structured and unstructured interviews can provide an accurate, realistic understanding of teenagers and their motivations for treatment.

A selected sample of assessment instruments follows:

Adolescent Drug Abuse Diagnosis (ADAD)

Contact: (215) 877-6408

Structured interview

Time: 45–55 minutes

Cost: \$15 per manual

Adolescent Diagnostic Interview (ADI)

Contact: (612) 626-2879

Structured interview

Time: 30–90 minutes

Cost: \$75 per kit

Adolescent Self-Assessment Profile (ASAP)

Contact: (303) 421-1261

Self-administered or structured interview

Time: 30–60 minutes

Cost: \$50 for fewer than 100 per year

Hilson Adolescent Profile (HAP)

Contact: (800) 926-2258

Individual or group interview

Time: 45 minutes

Cost: \$7.50–\$12 per test

Juvenile Automated Substance Abuse Evaluation (JASAE)

Contact: (248) 625-7200

adeinc@mail.tir.com

Personal interview

Time: 20 minutes

Cost: \$4.50 per evaluation

(Several comprehensive instruments are reviewed in TIP 31, appendix B. The KAP Keys based on TIPs 31 and 32 include a screening tool.)

Written Report

After completing the assessment, the assessor prepares a detailed written report that identifies

- The youth's environment
- The severity of the youth's substance use
- The youth's reasons for using substances
- The factors contributing to the youth's substance abuse
- The diagnosis (as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition [DSM-IV])
- The history of substance abuse and mental health treatment.

The written report should

- Outline a corrective plan addressing problem areas
- Provide links to needed services
- Specify treatment placement
- Recommend posttreatment support services

- Establish actions to ensure that the treatment plan is
 - Responsive to the adolescent's wishes
 - Implemented
 - Monitored to its conclusion
- Be distributed in compliance with the confidentiality requirements and with written approval
- Be understandable to all concerned parties.

TREATMENT PLACEMENT

Treatment placement options may be

- Outpatient
- Inpatient
- Residential
- Services supporting independent living.

These options are subdivided into specific services ranging from pretreatment (for atrisk adolescents) to intensive (for youths with substance use disorders).

The type of treatment selected is based on the client assessment criteria (see exhibit 31/32–3).

Exhibit 31/32-3
Client Assessment Criteria

If the Assessment Identifies	Treatment Option
No history of and no current substance use	Primary prevention
Past (but no current) use	Anticipatory guidance and support
Problems resulting from use or low-to-moderate current use	Brief office intervention or outpatient treatment
Problems resulting from use or moderate-to-heavy recent use	Intensive outpatient treatment, day treatment, partial hospitalization, other intensive levels of care

Placement Guidelines

When determining placement

- Assess medical concerns, substance use patterns, personal and interpersonal factors, and environmental influences
- Choose the most intensive level of care indicated by any assessment criterion (e.g., an adolescent who is not currently using substances but who

is actively psychotic would require inpatient treatment)

- Refer the adolescent to the next level of care if the needed level of care is not available.

TREATMENT LEVELS

Outpatient Treatment

Outpatient treatment services for adolescents range in intensity and do not include overnight accommodation. They may be used alone or after inpatient treatment. Sublevels include brief interventions, outpatient counseling, and day treatment (partial hospitalization).

Brief interventions

- Are based on motivational enhancement theory
- Use brief screening, anticipatory guidance, and psychoeducational interventions
- Are appropriate for adolescents in the low-to-middle severity range (i.e., experimental, regular, and problem use)
- Are less time consuming than more formal treatment approaches
- Are usually delivered by nonspecialists or paraprofessionals
- Emphasize self-help and self-management

- Reach many individuals
- Are less expensive than conventional treatment.

Outpatient counseling

- Uses professionally directed evaluation and treatment
- Involves several hours of treatment per week in regularly scheduled sessions
 - Nonintensive outpatient treatment may address related psychiatric, emotional, and social concerns in 2–3 hours per week.
 - Intensive outpatient programs are held after school or in the evening and on weekends involving 9–20 hours of treatment each week.

Day treatment or partial hospitalization

- Provides professional evaluation and treatment in a structured program
- Is the most intensive of the outpatient options
- Is appropriate for highly dysfunctional adolescents who do not require inpatient treatment.

Inpatient Treatment

Inpatient treatment may include 24-hour intensive medical, psychiatric, and/or psychosocial treatment and residential care. Sublevels are detoxification and residential treatment.

Detoxification

- Three- to five-day inpatient stay with 24-hour intensive medical management of severe withdrawal symptoms
- An adolescent's withdrawal is generally not severe enough to warrant detox except when psychosocial circumstances or personal characteristics warrant it or the use of a significant amount of a substance (e.g., benzodiazepines, barbiturates, heavy chronic alcohol use) will result in life-threatening withdrawal.

Residential treatment

- Is long term
- Uses psychosocial rehabilitation
- Is directed by physicians or other professionals
- Is appropriate for adolescents with multiple problems, especially those with coexisting disorders.

Continuing Care

- Provides a structured, time-limited outpatient program and planning process
- Uses a group approach to help transition from intensive treatment to a lower level of care
- Teaches relapse prevention (the greatest risk for relapse occurs immediately after completion of a treatment program)

- Should be included in all treatment plans.

Types of continuing care include

- Group homes (halfway houses or independent living)—Residents may work or attend educational/training services or treatment sessions outside the group home while in a transitional living arrangement with different treatment levels and staff supervision.
- “Booster” sessions—Teens periodically return to the treatment program to meet with clinicians and review their relapse prevention, selfmanagement, and independent living skills.
- Self-help/peer support groups—Youths attend Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Al-Anon, and Alateen.

Severity Continuum

Adolescent substance use can be placed on a continuum of severity that includes

- Abstinence
- Use: Minimal/experimental use with few consequences
- Abuse: Regular use with many or severe consequences
- Abuse/dependence: Regular use over an extended period with continued severe consequences

- Recovery: Return to abstinence, some relapses
- Secondary abstinence.

The treatment intervention continuum ranges from minimal outpatient contacts to long-term residential treatment. When determining the appropriate treatment referral, consider

- All levels of care
- The severity of the client's substance use.

Factors Affecting Treatment Placement

The most intensive treatment services should be provided to youths with

- Signs of dependence
- Many personal and social consequences of substance abuse.

TAILORING TREATMENT TO ADOLESCENTS

Treatment for adolescents works best when it addresses their particular needs and concerns.

When tailoring treatment to individual adolescents, counselors should consider

Developmental stages—Exhibit 31/32–4 presents adolescent developmental stages.

Exhibit 31/32-4
Features of Early and Later Adolescence

	Early (ages approximately 11–15)	Later (ages approximately 16–21)
Cognitive Thinking	<ul style="list-style-type: none">Concrete thinking emphasizing immediate reactionsYouths may not be aware of consequences	<ul style="list-style-type: none">Youths use more abstract thinking and inductive/deductive reasoningYouths are more introspective/sensitive to consequences
Task Areas Family Independence	<ul style="list-style-type: none">Youths begin rejecting parental guidanceYouths show ambivalence about wishes (dependence/independence)	<ul style="list-style-type: none">Youths insist on independence, privacyYouths may rebel or withdraw; test limits often
Peers	<ul style="list-style-type: none">Best friend is usually of the same gender	<ul style="list-style-type: none">Youths date; sexual experimentation is normalYouths take risks

	<ul style="list-style-type: none"> • Youths have sexual fantasies; have little if any sexual experimentation 	<ul style="list-style-type: none"> • Youths' need to please peers increases
<i>School and Vacation</i>	<ul style="list-style-type: none"> • Structured school setting preferred 	<ul style="list-style-type: none"> • Youths begin to identify skills, interests • Youths start part-time job
<i>Self-Perception, Identity, Social Responsibility, Values</i>	<ul style="list-style-type: none"> • Emphasis on "Am I normal?" • Tendency to denial ("It can't happen to me") 	<ul style="list-style-type: none"> • Youths conform to peer group values • Youths continue to pursue group/peer acceptance • Youths are able to reject group pressure if it is not in their best interests

(continued on next page)

Exhibit 31/32-4 (continued)

Features of Early and Later Adolescence

	Early (ages approximately 11–15)	Later (ages approximately 16–21)
Professional Approach	<ul style="list-style-type: none">• Provide firm, direct support• Convey limits (simple concrete choices)• Do not align with parents, but be an objective caring adult• Encourage transference	<ul style="list-style-type: none">• Be an objective sounding board (but let adolescents solve their own problems)• Negotiate choices• Be a role model• Don't ask for too much history ("grandiose stories")• Gently confront about consequences, responsibilities• Consider peer influences• Use peer group sessions• Adapt systems to crises, impulsiveness, testing of behaviors• Allow teens to seek care independently

The family—“Families” may include grandparents, siblings, and foster parents. Involve them in all phases of treatment. However, it may not be feasible to include families with histories of extreme instability, conflict, physical or sexual abuse, or domestic violence. Consider

- The family’s stability and commitment
- Parenting skills
- Degree of family conflict
- Bonding among family members
- Parental expectations
- Inconsistent discipline.

Ethnicity—Learn relevant information about clients’ culture (e.g., if parents are first-generation immigrants), and incorporate cultural traditions.

Gender—Female clients are more likely to have been sexually or physically abused or have children and often need highly specialized treatment services.

Coexisting disorders—Screen clients for psychiatric disorders, such as conduct and oppositional disorders, AD/HD, affective and anxiety disorders, and posttraumatic stress syndrome, and make referrals as needed.

Pharmacotherapy—When adolescents are prescribed medication for coexisting disorders, programs should suspend the “no medication” rule and monitor the adolescents as needed.

Environment—Treatment providers should understand the negative school, peer, and community influences and address these influences in treatment plans.

Key points about treating adolescents

- Not all adolescents who use substances are dependent. Do not prematurely diagnose or label adolescents (or pressure them to accept that they have an addictive disease).
- Consider adolescents’ developmental needs; younger teens have different needs than older ones.
- Many adolescents are coerced into treatment, which creates a barrier to behavior change.
- Many adolescents respond better to the motivational interviewing approach than to the confrontation of denial approach (exhibit 31/32-5).

Exhibit 31/32-5

Comparison of Confrontation-of-Denial and Motivational Interviewing Approaches

Confrontation of Denial	Motivational Interviewing
Emphasizes accepting problem/pathology, which reduces personal choice and control to occur	Deemphasizes labeling; client is not required to accept the disease diagnosis for change to occur
Therapist presents evidence to convince client to accept diagnosis	Therapist emphasizes personal choice and responsibility for deciding future behavior
Client resistance is seen as denial that requires confrontation	Therapist conducts an objective evaluation but elicits concerns
Therapist prescribes treatment goals/strategies without client's input; client is seen as in denial and incapable of making sound decisions	Client is involved in determining his or her treatment goals

GENERAL PROGRAM CHARACTERISTICS

Staff

The following services are provided by core staff

- Intake
- Screening
- Assessment (including a cultural assessment)
- Case management, including treatment planning and crisis intervention
- Substance treatment (individual, group, family)
- Education about substance use, HIV, and other STDs
- Continuing care planning
- Recordkeeping and report writing.

Programs may require additional psychologists, recreational and occupational therapists, disabilities specialists, and case managers to provide more intense treatment.

Skills Development

Adolescent treatment requires that clinical staff be knowledgeable about

- Diagnostic criteria for substance use disorders (e.g., DSM–IV criteria)

- Effective adolescent treatment approaches
- Family dynamics/therapy
- Adolescent growth/development
- Mental health issues
- Differences in cultural and ethnic values
- Psychopharmacology
- Group dynamics/therapy
- Legal issues
- Health issues.

Program Components

Some common components of adolescent treatment programs are

Orientation—Information about the program, the treatment process, and the adolescent's role in treatment is provided.

Daily scheduled activities—Most adolescents in treatment are preoccupied with using and have not developed positive recreational activities or living skills. A daily schedule of school, chores, and recreation prescribed by staff can help adolescents develop them.

Peer monitoring—Group therapy helps adolescents harness the positive peer group influences.

Client contracts—Provide

- Clear expectations about behavior and substance use
- Specific treatment goals
- Descriptions of consequences if contracts are broken
- Rewards if contracts are kept.

Schooling—Classroom schooling is mandated in some States in residential or day treatment. It can be provided onsite (by the program or homebound public school teachers) or offsite (in public settings) and

- Must be integrated into the clinical program and consider teachers part of the treatment team
- Have reasonable academic expectations for clients
- Develop criteria and procedures for making educational referrals
- Arrange for clients to receive academic credit from their regular school.

The Treatment Plan

The primary therapist or treatment team develops a treatment plan in concert with the client, the family, and staff of other involved or referring agencies. The plan identifies

- Target problems of the client and family
- Realistic goals (so clients recognize their substance involvement and personal responsibility for the resulting problems)
- Timeframes for achieving goals
- Treatment strategies
- Methods for measuring goal achievement.

Making Links to the Community

Programs treating adolescents should

- Work with other involved systems (e.g., school, child welfare, juvenile justice)
- Develop interagency agreements that describe all agencies' responsibilities in writing
- Network with community services
- Understand community reaction to the program's presence
- Establish a community advisory board.

TREATMENT MODELS

Some common treatment models for adolescents are 12-Step programs, therapeutic communities, and family therapy programs.

12-Step Programs

The 12-Step approach uses

- A strong AA orientation
- Skilled alcoholism counselors as primary therapists
- Medical and psychiatric support for coexisting disorders
- Group and family therapy
- Individualized counseling to address clients' special issues
- Family- and peer-oriented aftercare.

Self-help groups offer positive role models, nonusing friends, and help with learning to cope with relapse triggers and sober living.

12-Step Principles in Treatment. Most 12-Step programs concentrate on and present the first 5 steps during primary treatment as follows:

Step 1: We admitted we were powerless over alcohol—that our lives had become unmanageable.

Help teens review their substance use history and associate it with harmful consequences.

Step 2: We came to believe that a Power greater than ourselves could restore us to sanity. Simplify this step to “There is hope if you let yourself be helped.” One powerful way to convey this is by having new clients interact with those working this step successfully.

Step 3: We made a decision to turn our will and our lives over to the care of God as we understood Him. Simplify this as “Try making decisions in a different way; take others’ suggestions and permit others to help you.”

Step 4: We made a searching and fearless moral inventory of ourselves; Step 5: We admitted to God, to ourselves, and to another human being the exact nature of our wrongs. Steps 4 and 5 provide an opportunity for acceptance by others despite one’s shortcomings.

Therapeutic Communities (TCs)

Features of TCs are

- The community serves as the primary therapist. Although adolescents often have a primary counselor, everyone in the community has responsibility to act as therapists and teachers.

- Treatment is a community process.
- Peer-group meetings are led by an adolescent (with a staff facilitator).
- Nearly all activities are part of the therapeutic process.

This approach is important for teens because TCs function as families and teens can experience support and learn how to have and maintain positive interpersonal relationships.

TCs

- Create a safe, nurturing environment where teens can disclose sensitive events and feelings, such as sexual abuse
- Adhere to “cardinal rules” that prohibit substance use or possession, physical threats or violence, or sexual contact.

Treatment includes

- Progression through phases when teens demonstrate responsibility, self-awareness, and consideration for others
- Structured phases that provide increased responsibilities and privileges.

Adolescents learn important psychological and social tasks before proceeding to the next structured stage

and can join the outside community after becoming a responsible TC member.

Family Therapy

Family relationships are crucial in treatment. They work at the level of family change (e.g., parenting practices, family environment, problem solving) and consider adolescents' psychosocial environment.

Three paradigms of family therapy are

1. Substance use is caused by the family—this view is outdated due to new understanding of family dynamics.
2. Risk reduction (in adolescent prevention and treatment programs) works with families trying to reduce risk factors and increase protective factors.
3. The contemporary therapy approach, the multisystemic or multidimensional perspective, includes all family members and (sometimes) peers. The family or group is the patient because its members exert the most influence on adolescents. Contemporary family approaches target numerous systems—peers, school, and the neighborhood—that help maintain dysfunctional interactions in families.

Goals of contemporary multisystemic family therapy include

- Examining the underlying causes of dysfunctional interactions
- Encouraging healthier interactions
- Revitalizing interpersonal bonds
- Changing the way family members relate
- Helping family members change negative components of their interactions.

YOUTHS WITH DISTINCTIVE TREATMENT NEEDS

Youths Involved With the Juvenile Justice System

These youths have multiple problems and need early intervention; diversion or dispositional alternative programs are used for them that include

- Intensive community supervision where youths report to a probation counselor
- Day reporting centers offering education, recreation, or social services
- Day treatment providing education and social services
- Tracking (monitoring requirements such as attending school, counseling, or work)

- Home detention
- Restitution (rectifying the damage youths have caused)
- Community service (youths volunteering services benefiting the community).

Characteristics of *juvenile drug courts*

- Comprehensive intake assessments
- Being flexible and responsive to the needs of adolescents
- Coordination among the court, school system, treatment service provider, and other community agencies
- Using case management to provide supervision throughout the assessment, referral, and treatment processes
- Immediate use of sanctions for noncompliance and incentives to recognize progress.

Homeless and Precariously Housed Youths

Outreach programs should help these youths

- Find housing
- Deal with family problems
- Participate in job training and schooling
- Receive health care.

Lesbian, Gay, Bisexual, and Transgender Youths

- These youths risk being ostracized by family and friends and may be at high risk for developing substance use disorders.
- Effective treatment helps these youths deal with problems stemming from their sexual identity and orientation and substance abuse.

Youths With Coexisting Disorders

- Staff of both mental health and substance abuse treatment programs need training to diagnose and treat coexisting mental illness and substance use disorders.
- Youths' mental and behavioral disorder problems worsen with substance use.
- Emotionally disordered youths may use substances to cope with their psychological symptoms (anxiety or depression), which may worsen when substance use stops.
- Adolescents being treated for a substance use disorder and taking psychoactive medications for a coexisting psychiatric disorder should have routine urine testing.

Ordering Information

TIP 31

Screening and Assessing Adolescents for Substance Use Disorders

TIP 32

Treatment of Adolescents With Substance Use Disorders

TIP 31- and 32-Related Products

KAP Keys for Clinicians Based on TIPs 31 and 32

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Other HHS products that are relevant to this Quick Guide:

TIP 21: *Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System* **SMA 09-4073**

TIP 27: *Comprehensive Case Management for Substance Abuse Treatment* **SMA 08-4215**

TIP 34: *Brief Interventions and Brief Therapies for Substance Abuse* **SMA 09-3952**

See the inside back cover for ordering information for all TIPs and related products.

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